

AMENDED IN SENATE JUNE 11, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY MAY 14, 2009

AMENDED IN ASSEMBLY APRIL 30, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

## **ASSEMBLY BILL**

**No. 1383**

**Introduced by Assembly Member Jones  
(Coauthor: Assembly Member De Leon)**

February 27, 2009

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An act to add and repeal Articles 5.21 (commencing with Section 14167.1) and 5.22 (commencing with Section 14167.31) of, Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

### LEGISLATIVE COUNSEL'S DIGEST

AB 1383, as amended, Jones. Medi-Cal: hospitals: supplemental payments: coverage dividend fee.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Under existing law, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, specified hospital reimbursement methodologies are applied in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients.

This bill would require the department to pay specified hospitals supplemental amounts for certain hospital services provided on or before December 31, 2010. This bill would require the supplemental payments to be made to hospitals at certain specified dates depending upon the federal fiscal year for which the payments are being made.

This bill would prohibit the payment rates for specified hospitals for certain services furnished before October 1, 2011, exclusive of amounts payable pursuant to this bill, from being reduced below the rates in effect on June 30, 2008. The bill would also prohibit the payment rates for hospital inpatient services furnished before October 1, 2011, under contracts negotiated pursuant to specified provisions of existing law, from being reduced below the contract rates in effect on June 1, 2009.

This bill would require the Director of Health Care Services to promptly seek the federal approvals ~~and~~, *waivers, waiver modifications, and any other federal action* that may be necessary to implement the bill. *The bill would, on or before June 30, 2009, require the director to submit any Medicaid state plan amendment necessary to implement the provisions of this bill for some or all of the federal fiscal year ending September 30, 2009. The bill would separately require the director to submit a Medicaid state plan amendment request on or before September 30, 2009 to implement the provisions of this bill for some or all of the period beginning October 1, 2009, and ending December 31, 2010. The bill would also require the director to request from the federal government certain written assurances from the Secretary of the United States Department of Health and Human Services. The bill provides that the supplemental payment provisions shall not be implemented unless and until the written assurances are obtained from the federal government.*

The bill would repeal the provisions regarding the supplemental payments on the earlier of January 1, 2013, or the date the director executes a declaration stating that a final judicial or administrative determination has been made, as specified, that any of the above provisions cannot be implemented.

This bill would require the department to calculate and impose a coverage dividend fee on certain hospitals starting on the date that the bill becomes effective and continue through and including December 31, 2010, as specified. This bill would require the director to seek federal approval of the fee and provides that if approval is denied, the provisions regarding the fee shall become inoperative. The bill would provide that no hospital shall be required to pay the coverage dividend fee to the

department unless and until the state receives and maintains federal approval of the fee from the federal Centers for Medicare and Medicaid Services.

This bill would provide that for calendar quarters prior to federal approval of the fee and for the calendar quarter when the department receives notice of federal approval, a hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it ~~has set aside in a separate account~~ *is prepared to pay* an amount equal to the coverage dividend fee for that hospital, as specified. The bill would require hospitals, ~~within 30 days after federal approval a specified period of time depending upon when the fee was assessed,~~ to pay the principal amount of the coverage dividend fee ~~set aside in a separate account it certified that it was prepared to pay~~ to the department, as specified. ~~The bill would permit any money set aside in a separate account in excess of the amount a hospital is obligated to pay to the department to be returned to the general accounts of each hospital.~~

By expanding the definition of the crime of perjury, this bill would create a state-mandated local program.

This bill would require the department, within 10 days of receiving federal approval, to send notice to providers, and publish on its Internet Web site, certain information regarding the coverage dividend fee. This bill would require, upon federal approval, that within 45 days following the beginning of each calendar quarter, commencing with the quarter in which the department receives federal approval and ending with, and including, the calendar quarter ending December 31, 2010, each hospital pay the department the coverage dividend fee, as specified. This bill would authorize the department, if a hospital fails to pay all or part of the coverage dividend fee within 60 days of the date that payment is due, to deduct the unpaid assessment and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered.

This bill would create the Coverage Dividend Revenue Fund in the State Treasury and require the money collected from the coverage dividend fee to be deposited into the fund. The money in the fund would be continuously appropriated without regard to fiscal year to the department for the purpose of making the above-described supplemental reimbursement or expanding health care coverage for children, with the supplemental reimbursement taking priority over the expansion of health care coverage for children.

This bill would authorize the department, in consultation with the hospital community, to modify any methodology regarding the supplemental payments or the coverage dividend fee to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided modifications do not violate the intent of the provisions of this bill and are not inconsistent with specified conditions of implementation.

The bill would repeal the provisions regarding the coverage dividend fee on the earlier of January 1, 2013, or the date the director executes a declaration stating either that any of specified conditions have not been met, the date that a final judicial or administrative determination has been made, as specified, that the coverage dividend fee cannot be implemented, or that federal approval for the fee has been denied.

*This bill provides that it is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the supplemental payment to individual hospitals and the amount of the coverage dividend fee due from individual hospitals. The bill provides that no supplemental payment shall be paid or coverage dividend fee made due or payable until the above-described legislation has been enacted.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote:  $\frac{2}{3}$ . Appropriation: yes. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Article 5.21 (commencing with Section 14167.1)
- 2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
- 3 Institutions Code, to read:
- 4
- 5 Article 5.21. Medi-Cal Hospital Provider Rate Stabilization
- 6 Act
- 7
- 8 ~~14167.1. (a)~~

1     14167.1. (a) “Aggregate designated public hospital amount”  
2     means, for an applicable federal fiscal year, an amount that would  
3     equitably reimburse the designated public hospitals for a portion  
4     of their costs of hospital services covered under the Medi-Cal  
5     program for the entire federal fiscal year, taking into account the  
6     supplemental payments made to other hospitals under this article,  
7     the amount of the coverage dividend fee, and the amount of the  
8     coverage dividend fee used to expand coverage, multiplied by the  
9     percentage of the federal upper payment limit room paid to private  
10    hospitals for hospital inpatient services under this article.

11    (b) “Aggregate managed care payment enhancement” means,  
12    for a subject federal fiscal year, the aggregate amount of the  
13    coverage dividend fee paid by hospitals for the subject federal  
14    fiscal year under Article 5.22 (commencing with Section 14167.31)  
15    less the nonmanaged care fee payments for the subject federal  
16    fiscal year.

17    (c) “Current Section 1115 Waiver” means California’s  
18    Medi-Cal Hospital/Uninsured Care Section 1115 Waiver  
19    Demonstration in effect on the effective date of this article.

20    (d) “Designated public hospital” means any one of the following  
21    hospitals:

- 22       (1) UC Davis Medical Center.
- 23       (2) UC Irvine Medical Center.
- 24       (3) UC San Diego Medical Center.
- 25       (4) UC San Francisco Medical Center.
- 26       (5) UC Los Angeles Medical Center, including Santa  
27       Monica-UCLA Medical Center.
- 28       (6) LA County Harbor-UCLA Medical Center.
- 29       (7) LA County Olive View-UCLA Medical Center.
- 30       (8) LA County Rancho Los Amigos National Rehabilitation  
31       Center.
- 32       (9) LA County University of Southern California Medical  
33       Center.
- 34       (10) Alameda County Medical Center.
- 35       (11) Arrowhead Regional Medical Center.
- 36       (12) Contra Costa Regional Medical Center.
- 37       (13) Kern Medical Center.
- 38       (14) Natividad Medical Center.
- 39       (15) Riverside County Regional Medical Center.
- 40       (16) San Francisco General Hospital.

- 1 (17) San Joaquin General Hospital.  
2 (18) San Mateo Medical Center.  
3 (19) Santa Clara Valley Medical Center.  
4 (20) Ventura County Medical Center.

5 ~~(b)~~

6 (e) “Federal upper payment limit” means the upper payment  
7 limit on the applicable category of hospitals pursuant to federal  
8 law that will be allowed for purposes of federal financial  
9 participation. The federal upper payment limit for hospital  
10 outpatient services is as set forth in Section 447.321 of Title 42 of  
11 the Code of Federal Regulations. The federal upper payment limit  
12 for hospital inpatient services is as set forth in Section 447.272 of  
13 Title 42 of the Code of Federal Regulations.

14 (f) “Federal upper payment limit room” means, for a subject  
15 federal fiscal year, the amount by which the federal upper payment  
16 limit exceeds the Medi-Cal payments for the services subject to  
17 the federal upper payment limit exclusive of payments made under  
18 this article.

19 ~~(e)~~

20 (g) “Hospital inpatient services” means all services covered  
21 under the Medi-Cal program and furnished by hospitals to patients  
22 who are admitted as hospital inpatients and reimbursed on a  
23 fee-for-service basis by the department directly or through its fiscal  
24 intermediary. Hospital inpatient services include outpatient services  
25 furnished by a hospital to a patient who is admitted to that hospital  
26 within 24 hours of the provision of the outpatient services that are  
27 related to the condition for which the patient is admitted. Hospital  
28 inpatient services include physician services only if the service is  
29 furnished to a hospital inpatient, the physician is compensated by  
30 the hospital for the service, and the service is billed to the Medi-Cal  
31 program by the hospital under a provider number assigned to the  
32 hospital. Hospital inpatient services do not include services for  
33 which a managed care health plan is financially responsible.

34 (h) “Hospital litigant means” a hospital that initiates, or on  
35 whose behalf is initiated, a case or proceeding in any state or  
36 federal court in which the hospital seeks any relief of any sort  
37 whatsoever, including, but not limited to, monetary relief, injunctive  
38 relief, declaratory relief, or a writ, based in whole or in part on a  
39 contention that any or all of this article or Article 5.22  
40 (commencing with Section 14167.31) is unlawful and may not be

1 *lawfully implemented. A hospital on whose behalf a case or*  
2 *proceeding described in this subdivision is brought shall not be a*  
3 *hospital litigant if the hospital successfully opts out or is dismissed*  
4 *from the case or proceeding so that the hospital will not be in a*  
5 *position to receive a benefit as a result of the case or proceeding.*

6 ~~(d)~~

7 (i) “Hospital outpatient services” means all services covered  
8 under the Medi-Cal program furnished by hospitals to patients  
9 who are registered as hospital outpatients and reimbursed by the  
10 department on a fee-for-service basis directly or through its fiscal  
11 intermediary. Hospital outpatient services include physician  
12 services only if the service is furnished to a hospital outpatient,  
13 the physician is compensated by the hospital for the service, and  
14 the service is billed to the Medi-Cal program by the hospital under  
15 a provider number assigned to the hospital. Hospital outpatient  
16 services do not include services for which a managed health care  
17 plan is financially responsible or services rendered by a  
18 hospital-based federally qualified health center that receives  
19 reimbursement pursuant to Section 14132.100.

20 ~~(e) “Implementation date” means the effective date of all federal~~  
21 ~~approvals or waivers necessary for implementation of this article.~~

22 (j) “Inpatient share percentage” means the percentage of total  
23 Medi-Cal acute care inpatient hospital days covered by all  
24 managed health care plans that the department estimates will be  
25 covered by a particular managed care health plan for the portion  
26 of a subject federal fiscal year that begins on or after the phase 1  
27 implementation date and ends on or before December 31, 2010.  
28 For purposes of this subdivision, Medi-Cal acute care inpatient  
29 hospital days covered by a managed health care plan shall include  
30 only days of service covered under a written contract between a  
31 managed health care plan and a private hospital, a nondesignated  
32 public hospital, or a designated public hospital.

33 ~~(f)~~

34 (k) “Managed care inpatient day” means an acute inpatient day  
35 of service covered under the Medi-Cal program for which a  
36 managed care health plan is financially responsible and that is  
37 covered by a written contract between a managed care health plan  
38 and a hospital or a hospital system.

39 ~~(g)~~

(l) “Managed health care plan” means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries. Managed health care plans include, but are not limited to, county organized health systems, prepaid health plans and entities contracting with the department to provide services pursuant to two-plan models, and geographic managed care. Entities providing these services contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8.

~~(h)~~

(m) “Nondesignated public hospital” means a public hospital that is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital’s annual financial disclosure report for the hospital’s latest fiscal year ending in 2008, and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(n) “Nonmanaged care fee payments” means, for a subject federal fiscal year, the aggregate amount paid for services furnished during the subject federal fiscal year under Sections 14167.2, 14167.3, 14167.4, and 14167.5 plus the coverage enhancement amount for the subject federal fiscal year.

~~(i)~~

(o) “Outpatient base rates” means the Medi-Cal payment rates for hospital outpatient services in effect on the date immediately preceding the implementation date.

(p) “Phase 1” means the implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(q) “Phase 1 approval” means the federal approvals or waivers necessary for implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(r) “Phase 1 implementation date” means the effective date of all federal approvals or waivers necessary for implementation of this article for some or all of the federal fiscal year ending September 30, 2009.



1 (s) “Phase 2” means the implementation of this article for some  
2 or all of the period beginning October 1, 2009, and ending  
3 December 31, 2010.

4 (t) “Phase 2 approval” means the federal approvals or waivers  
5 necessary for implementation of this article for the period  
6 beginning October 1, 2009, and ending December 31, 2010.

7 (u) “Phase 2 implementation date” means the effective date of  
8 all federal approvals or waivers necessary for implementation of  
9 this article for the period beginning October 1, 2009, and ending  
10 December 31, 2010.

11 (j)

12 (v) “Private hospital” means a hospital licensed pursuant to  
13 subdivision (a) of Section 1250 of the Health and Safety Code, is  
14 not designated as a specialty hospital in the hospital’s annual  
15 financial disclosure report for the hospital’s latest fiscal year ending  
16 in 2008, and is a nonpublic hospital, nonpublic-converted hospital,  
17 or converted hospital as those terms are defined in paragraphs (26)  
18 to (28), inclusive, respectively, of subdivision (a) of Section  
19 14105.98.

20 (k)

21 (w) “Subject federal fiscal year” means a federal fiscal year that  
22 ends after the *phase 1* implementation date and begins before the  
23 termination date.

24 (t)

25 (x) “Termination date” means December 31, 2010.

26 ~~14167.2.—(a) Private hospitals shall be paid supplemental~~  
27 ~~amounts for hospital outpatient services provided on or before~~  
28 ~~December 31, 2010, that shall be in addition to any other amounts~~  
29 ~~payable to hospitals with respect to hospital outpatient services~~  
30 ~~and shall not affect any other payments to hospitals.~~

31 ~~(b) Medi-Cal rates for hospital outpatient services provided on~~  
32 ~~or before December 31, 2010, shall result in aggregate payments~~  
33 ~~equal to the federal upper payment limit.~~

34 ~~14167.3.—(a) Hospitals shall be paid supplemental amounts for~~  
35 ~~hospital inpatient services provided on or before December 31,~~  
36 ~~2010, that shall be in addition to any other amounts payable to~~  
37 ~~hospitals with respect to hospital inpatient services and shall not~~  
38 ~~affect any other payments to hospitals.~~

1     ~~(b) Medi-Cal rates for hospital inpatient services provided on~~  
2     ~~or before December 31, 2010, shall result in aggregate payments~~  
3     ~~equal to the federal upper payment limit.~~

4     ~~14167.4. Private hospitals, nondesignated public hospitals, and~~  
5     ~~designated public hospitals shall be paid supplemental amounts~~  
6     ~~for hospital services provided on or before December 31, 2010,~~  
7     ~~that are furnished to managed care enrollees pursuant to this~~  
8     ~~section. The supplemental amounts shall be paid directly to the~~  
9     ~~hospitals by the department or its fiscal intermediary in addition~~  
10    ~~to any other amounts payable to hospitals with respect to hospital~~  
11    ~~services furnished to managed care enrollees and shall not affect~~  
12    ~~any other payments to hospitals.~~

13    ~~14167.5. The amount of any payments made pursuant to this~~  
14    ~~article to private hospitals, including the amount of payments made~~  
15    ~~pursuant to Sections 14167.2, 14167.3, and 14167.4, shall not be~~  
16    ~~included in the calculation of the numerator or denominator of the~~  
17    ~~low-income percent of the OBRA limit for purposes of~~  
18    ~~disproportionate share hospital replacement fund payments to~~  
19    ~~private hospitals made pursuant to Section 14166.11.~~

20    ~~14167.6. (a) The payments made pursuant to Sections 14167.2,~~  
21    ~~14167.3, and 14167.4 to hospitals for the 2008–09 federal fiscal~~  
22    ~~year shall be made on or before the later of August 31, 2009, or~~  
23    ~~the 30th day following the day on which federal approval is~~  
24    ~~granted.~~

25    ~~(b) The payments made pursuant to Sections 14167.2, 14167.3,~~  
26    ~~and 14167.4 to hospitals for 2009–10 federal fiscal year shall be~~  
27    ~~made on a quarterly basis. The amounts payable to a hospital for~~  
28    ~~each quarter shall be one-fourth of the amount payable to the~~  
29    ~~hospital for the entire federal fiscal year. Payments to hospitals~~  
30    ~~for each quarter during the 2009–10 federal fiscal year shall be~~  
31    ~~made on the later of the last day of the second month of the quarter~~  
32    ~~or the 30th day following the day on which federal approval is~~  
33    ~~granted.~~

34    ~~(c) The payments made pursuant to Sections 14167.2, 14167.3,~~  
35    ~~and 14167.4 to hospitals for the 2010–11 federal fiscal year shall~~  
36    ~~be made on or before the later of November 30, 2010, or the 30th~~  
37    ~~day following the day on which federal approval is granted.~~

38    ~~14167.2. (a) Private hospitals shall be paid supplemental~~  
39    ~~amounts for hospital outpatient services provided on or after the~~  
40    ~~phase 1 implementation date and on or before September 30, 2009,~~

1 *that shall be in addition to any other amounts payable to hospitals*  
2 *with respect to hospital outpatient services. These supplemental*  
3 *payments shall not affect any other payments to hospitals.*

4 *(b) Medi-Cal rates for hospital outpatient services provided on*  
5 *or after the phase 1 implementation date and on or before*  
6 *September 30, 2009, shall result in aggregate payments equal to*  
7 *the federal upper payment limit for the federal fiscal year ending*  
8 *September 30, 2009, or the portion of the federal fiscal year that*  
9 *is approved by the federal government if the federal government*  
10 *approves the utilization of the federal upper payment limit room*  
11 *for less than the entire federal fiscal year.*

12 *14167.3. (a) Private hospitals shall be paid supplemental*  
13 *amounts for hospital inpatient services provided on or after the*  
14 *phase 1 implementation date and on or before September 30, 2009,*  
15 *that shall be in addition to any other amounts payable to private*  
16 *hospitals with respect to hospital inpatient services. These*  
17 *supplemental payments shall not affect any other payments to*  
18 *private hospitals.*

19 *(b) Medi-Cal rates for hospital inpatient services provided by*  
20 *private hospitals on or after the phase 1 implementation date and*  
21 *on or before September 30, 2009, shall result in aggregate*  
22 *payments equal to the federal upper payment limit for the federal*  
23 *fiscal year ending September 30, 2009, or the portion of the federal*  
24 *fiscal year that is approved by the federal government if the federal*  
25 *government approves the utilization of the federal upper payment*  
26 *limit room for less than the entire federal fiscal year.*

27 *14167.4. (a) Nondesignated public hospitals shall be paid*  
28 *supplemental amounts for hospital inpatient services provided on*  
29 *or after the phase 1 implementation date and on or before*  
30 *September 30, 2009, that shall be in addition to any other amounts*  
31 *payable to nondesignated public hospitals with respect to hospital*  
32 *inpatient services. These supplemental payments shall not affect*  
33 *any other payments to nondesignated public hospitals.*

34 *(b) Medi-Cal rates for hospital inpatient services provided by*  
35 *nondesignated public hospitals on or after the phase 1*  
36 *implementation date and on or before September 30, 2009, shall*  
37 *result in aggregate payments equal to the portion of the federal*  
38 *upper payment limit allocable to nondesignated public hospitals*  
39 *for the subject federal fiscal year ending September 30, 2009, or*  
40 *the portion of the federal fiscal year that is approved by the federal*

1 government if the federal government approves the utilization of  
2 the federal upper payment limit room for less than the entire  
3 federal fiscal year.

4 14167.5. Designated public hospitals shall be paid additional  
5 Medi-Cal reimbursement for hospital services they provide on or  
6 after the phase 1 implementation date and on or before September  
7 30, 2009. The amount paid under this section shall in the aggregate  
8 be the aggregate designated public hospital amount for the subject  
9 federal fiscal year ending September 30, 2009, less the amount  
10 paid to designated public hospitals under Section 14167.6 for  
11 services rendered during the federal fiscal year ending September  
12 30, 2009.

13 14167.6. (a) The department shall increase payments in the  
14 aggregate to Medi-Cal managed health care plans for the provision  
15 of Medi-Cal services on or after the phase 1 implementation date  
16 and on or before September 30, 2009, in the amount of the  
17 aggregate managed care hospital payment enhancement.

18 (b) The department shall increase payments for the subject  
19 federal fiscal year ending September 30, 2009, to each Medi-Cal  
20 managed health care plan that furnishes or is responsible for  
21 furnishing hospital inpatient services a percentage of the aggregate  
22 managed care hospital payment enhancement equal to the  
23 department's estimate of the managed health care plan's inpatient  
24 share percentage for the period beginning on the phase 1  
25 implementation date and ending September 30, 2009.

26 (c) The department shall estimate before the phase 1  
27 implementation date each managed health care plan's inpatient  
28 percentage using the methods and data that the department  
29 determines is appropriate.

30 (d) The department may adjust managed care plans' inpatient  
31 percentages during the federal fiscal year ending September 30,  
32 2009, to reflect changes in Medi-Cal enrollment among health  
33 plans during the fiscal year, provided that the sum of all managed  
34 care plan's inpatient share percentages shall always total 100  
35 percent.

36 (e) Each Medi-Cal managed health care plan shall equitably  
37 expend, in the form of additional payments to hospitals for  
38 managed care inpatient days, 100 percent of any rate increase it  
39 receives under this section. The amount of the additional payments  
40 shall be determined on a per diem basis so that each hospital

1 receives the same additional amount per managed care inpatient  
2 day furnished during a calendar quarter. Any delegation or  
3 attempted delegation by a Medi-Cal managed health care plan of  
4 its obligation to make payments under this section shall not relieve  
5 the managed health care plan from its obligation to make the  
6 payments. Medi-Cal managed health care plans shall submit the  
7 documentation the department may require to demonstrate  
8 compliance with the provisions of this subdivision. The  
9 documentation shall be available to hospitals for inspection and  
10 copying under the California Public Records Act (Chapter 3.5  
11 (commencing with Section 6250) of Division 7 of Title 1 of the  
12 Government Code), and no exemption from disclosure under the  
13 California Public Records Act shall apply as to hospitals.

14 14167.8. The payments made pursuant to Sections 14167.2,  
15 14167.3, 14167.4, 14167.5, and 14167.6 to hospitals and managed  
16 health care plans for the 2008–09 federal fiscal year shall be made  
17 on or before the later of August 31, 2009, or the 30th day following  
18 the date on which phase 1 approval is granted.

19 14167.9. (a) Private hospitals shall be paid supplemental  
20 amounts for hospital outpatient services provided on or after the  
21 phase 2 implementation date and on or before December 31, 2010,  
22 that shall be in addition to any other amounts payable to hospitals  
23 with respect to hospital outpatient services. These supplemental  
24 payments shall not affect any other payments to hospitals.

25 (b) Medi-Cal rates for hospital outpatient services provided on  
26 or after the phase 2 implementation date and on or before  
27 December 31, 2010, shall result in aggregate payments equal to  
28 the federal upper payment limit for the subject federal fiscal year  
29 during which the services are rendered or the portion of the subject  
30 federal fiscal year that is approved by the federal government if  
31 the federal government approves the utilization of the federal upper  
32 payment limit room for less than the entire subject federal fiscal  
33 year.

34 14167.10. (a) Private hospitals shall be paid supplemental  
35 amounts for hospital inpatient services provided on or after the  
36 phase 2 implementation date and on or before December 31, 2010,  
37 that shall be in addition to any other amounts payable to private  
38 hospitals with respect to hospital inpatient services. These  
39 supplemental payments shall not affect any other payments to  
40 private hospitals.

1     (b) *Medi-Cal rates for hospital inpatient services provided by*  
2 *private hospitals on or after the phase 2 implementation date and*  
3 *on or before December 31, 2010, shall result in aggregate*  
4 *payments equal to the federal upper payment limit for the subject*  
5 *federal fiscal year during which the services are rendered or the*  
6 *portion of the subject federal fiscal year that is approved by the*  
7 *federal government if the federal government approves the*  
8 *utilization of the federal upper payment limit room for less than*  
9 *the entire subject federal fiscal year.*

10     14167.11. (a) *Nondesignated public hospitals shall be paid*  
11 *supplemental amounts for hospital inpatient services provided on*  
12 *or after the phase 2 implementation date and on or before*  
13 *December 31, 2010, that shall be in addition to any other amounts*  
14 *payable to nondesignated public hospitals with respect to hospital*  
15 *inpatient services. These supplemental payments shall not affect*  
16 *any other payments to nondesignated public hospitals.*

17     (b) *Medi-Cal rates for hospital inpatient services provided by*  
18 *nondesignated public hospitals on or after the phase 2*  
19 *implementation date and on or before December 31, 2010, shall*  
20 *result in aggregate payments equal to the portion of the federal*  
21 *upper payment limit allocable to nondesignated public hospitals*  
22 *for the subject federal fiscal year during which the services are*  
23 *rendered or the portion of the subject federal fiscal year that is*  
24 *approved by the federal government if the federal government*  
25 *approves the utilization of the federal upper payment limit room*  
26 *for less than the entire subject federal fiscal year.*

27     14167.12. *Designated public hospitals shall be paid additional*  
28 *Medi-Cal reimbursement for hospital services for each subject*  
29 *federal fiscal year which begins on or after the phase 2*  
30 *implementation date and ends on or before September 30, 2011.*  
31 *The amount paid under this section for a subject federal fiscal*  
32 *year shall in the aggregate be the aggregate designated public*  
33 *hospital amount for the subject federal fiscal year less the amount*  
34 *paid to designated public hospitals under Section 14167.13 for*  
35 *services rendered during the subject federal fiscal year.*

36     14167.13. (a) *The department shall increase payments in the*  
37 *aggregate to Medi-Cal managed health care plans for the provision*  
38 *of Medi-Cal services for each subject federal fiscal year which*  
39 *begins on or after the phase 2 implementation date and ends on*

1 *or before September 30, 2011, in the amount of the aggregate*  
2 *managed care hospital payment enhancement.*

3 *(b) The department shall increase payments for each subject*  
4 *federal fiscal year to each Medi-Cal managed health care plan*  
5 *that furnishes or is responsible for furnishing hospital inpatient*  
6 *services a percentage of the aggregate managed health care*  
7 *hospital payment enhancement equal to the department's estimate*  
8 *of the managed health care plan's inpatient share percentage for*  
9 *the subject federal fiscal year.*

10 *(c) The department shall estimate before the implementation*  
11 *date and the beginning of each subject federal fiscal year beginning*  
12 *on or after the implementation date each managed health care*  
13 *plan's inpatient percentage using methods and data that the*  
14 *department determines is appropriate.*

15 *(d) The department may adjust managed health care plans'*  
16 *inpatient percentages during a subject federal fiscal year to reflect*  
17 *changes in Medi-Cal enrollment among plans during the fiscal*  
18 *year, provided that the sum of all managed health care plan's*  
19 *inpatient share percentages must always total 100 percent.*

20 *(e) Each Medi-Cal managed health care plan shall equitably*  
21 *expend, in the form of additional payments to hospitals for*  
22 *managed care inpatient days, 100 percent of any rate increase it*  
23 *receives under this section. The amount of the additional payments*  
24 *shall be determined on a per diem basis so that each hospital*  
25 *receives the same additional amount per managed care inpatient*  
26 *day furnished during a calendar quarter. Any delegation or*  
27 *attempted delegation by a Medi-Cal managed health care plan of*  
28 *its obligation to make payments under this section shall not relieve*  
29 *the managed care plan from its obligation to make the payments.*  
30 *Medi-Cal managed health care plans shall submit the*  
31 *documentation that the department may require to demonstrate*  
32 *compliance with the provisions of this subdivision. The*  
33 *documentation shall be available to the public under the California*  
34 *Public Records Act (Chapter 3.5 (commencing with Section 6250)*  
35 *of Division 7 of Title 1 of the Government Code), and no exemption*  
36 *from disclosure under the California Public Records Act shall*  
37 *apply.*

38 *14167.14. The amount of any payments made pursuant to this*  
39 *article to private hospitals, made either directly or by managed*  
40 *health care plans pursuant to sections 14167.6 and 14167.13, shall*

1 *not be included in the calculation of the numerator or denominator*  
2 *of the low-income percent of the OBRA limit for purposes of*  
3 *disproportionate share hospital replacement fund payments to*  
4 *private hospitals made pursuant to Section 14166.11.*

5 *14167.15. (a) The payments made pursuant to Sections*  
6 *14167.9, 14167.10, 14167.11, 14167.12, and 14167.13 to hospitals*  
7 *and managed health care plans for the 2009–10 federal fiscal year*  
8 *shall be made on a quarterly basis. The amounts payable to the*  
9 *hospital for each quarter shall be one-fourth of the amount payable*  
10 *to the hospital for the entire federal fiscal year. Payments to*  
11 *hospitals for each quarter during the 2009–10 federal fiscal year*  
12 *shall be made on the later of the last day of the second month of*  
13 *the quarter or the 30th day following the day on which phase 2*  
14 *federal approval is granted.*

15 *(b) The payments made pursuant to Sections 14167.9, 14167.10,*  
16 *14167.11, 14167.12, and 14167.13 to hospitals and managed*  
17 *health care plans for the 2010–11 federal fiscal year shall be made*  
18 *on or before the later of November 30, 2010, or the 30th day*  
19 *following the day on which phase 2 federal approval is granted.*

20 ~~14167.7.~~

21 *14167.16. (a) Payment rates for hospital outpatient services*  
22 *furnished by private hospitals and nondesignated public hospitals*  
23 *before October 1, 2011, exclusive of amounts payable under this*  
24 *article, shall not be reduced below the rates in effect on June 30,*  
25 *2008.*

26 *(b) Rates payable to hospitals for hospital inpatient services*  
27 *furnished before October 1, 2011, under contracts negotiated*  
28 *pursuant to the Selective Provider Contracting Program shall not*  
29 *be reduced below the contract rates in effect on June 1, 2009. This*  
30 *subdivision shall not prohibit changes to the supplemental*  
31 *payments paid to individual hospitals pursuant to Sections*  
32 *14166.12, 14166.17, and 14166.23. The aggregate supplemental*  
33 *payments made pursuant to Sections 14166.12, 14166.17, and*  
34 *14166.23 for a state fiscal year that ends after the implementation*  
35 *date and begins before the termination date shall not be less than*  
36 *the aggregate payments made pursuant to Sections 14166.12,*  
37 *14166.17, and 14166.23 during the 2007–08 state fiscal year.*

38 *(c) Payments to private hospitals and nondesignated public*  
39 *hospitals for hospital inpatient services furnished before October*  
40 *1, 2011, that are not reimbursed pursuant to a contract negotiated*



1 pursuant to the Selective Provider Contracting Program (Article  
2 2.6 (commencing with Section 14081)), exclusive of amounts  
3 payable under this article, shall not be less than the amount of  
4 payments that would have been made pursuant to the payment  
5 methodology in effect on June 30, 2008.

6 (d) Payments to hospitals pursuant to Sections 14166.11 and  
7 14166.16 for a state fiscal year that ends after the implementation  
8 date and begins before the termination date shall not be less than  
9 the payments due under the methodology set forth in those sections  
10 in effect for the 2007–08 state fiscal year.

11 (e) Managed care health plans shall not take into account  
12 payments made pursuant to this article in negotiating the amount  
13 of payments to hospitals that are not made pursuant to this article.

14 ~~14167.8. (a) The director shall promptly seek the federal~~  
15 ~~approvals or waivers as may be necessary to implement this article~~  
16 ~~and obtain federal financial participation to the maximum extent~~  
17 ~~possible for the payments made pursuant to this article.~~

18 ~~(b) In implementing this article, the department may utilize the~~  
19 *14167.17. (a) The director shall promptly seek the federal*  
20 *approvals, waivers, waiver modifications, and any other federal*  
21 *action as may be necessary to implement phase 1 and obtain*  
22 *federal financial participation to the maximum extent possible for*  
23 *the payments made with respect to phase 1. The director shall*  
24 *submit any Medicaid state plan amendment that may be necessary*  
25 *to implement phase 1 on or before June 30, 2009.*

26 *(b) The director shall request from the federal government, in*  
27 *connection with obtaining federal approval for phase 1, the*  
28 *following written assurances from the Secretary of the United*  
29 *States Department of Health and Human Services:*

30 *(1) The approval of phase 1 will not result in funding reductions*  
31 *to hospitals under the current Section 1115 Waiver.*

32 *(2) The federal Centers for Medicare and Medicaid Services*  
33 *will explore, with the state, the need for growth in the safety net*  
34 *care pool established pursuant to the current Section 1115 Waiver.*

35 *(3) The additional federal funding provided for the 2008–09*  
36 *federal fiscal year as a result of the implementation of phase 1*  
37 *will not be taken into account in the determination of the amount*  
38 *of federal funds that will be available pursuant to a waiver under*  
39 *Section 1115 of the federal Social Security Act for a demonstration*

1 *which will replace the current Section 1115 Waiver except as it*  
2 *may increase the amount available under budget neutrality.*

3 *(4) The funding and reimbursement protocol for claiming*  
4 *against the safety net care pool will not be amended for the*  
5 *duration of the current Section 1115 Waiver.*

6 *(c) Phase 1 shall not be implemented unless and until written*  
7 *assurances substantially as described in subdivision (b) are*  
8 *obtained from the federal government.*

9 *14167.18. (a) The director shall submit a Medicaid state plan*  
10 *amendment for phase 2 to the federal government on or before*  
11 *September 30, 2009, and shall seek all federal approvals, waivers,*  
12 *waiver modifications, and any other federal action as may be*  
13 *necessary to implement phase 2 and obtain federal financial*  
14 *participation to the maximum extent possible for the payments*  
15 *made with respect to phase 2.*

16 *(b) The director shall negotiate the federal approvals required*  
17 *to implement phase 2 concurrently with the negotiation of a federal*  
18 *waiver under Section 1115 of the federal Social Security Act for*  
19 *a demonstration that will replace the current Section 1115 Waiver.*

20 *(c) Phase 2 shall not be implemented unless and until the federal*  
21 *government approves a federal waiver under Section 1115 of the*  
22 *federal Social Security Act for a demonstration that will replace*  
23 *the current Section 1115 Waiver.*

24 *14167.19. (a) In implementing this article, the department*  
25 *may utilize the services of the Medi-Cal fiscal intermediary through*  
26 *a change order to the fiscal intermediary contract to administer*  
27 *this program, consistent with the requirements of Sections 14104.6,*  
28 *14104.7, 14104.8, and 14104.9. Contracts entered into with any*  
29 *Medi-Cal fiscal intermediary shall not be subject to Part 2*  
30 *(commencing with Section 10100) of Division 2 of the Public*  
31 *Contract Code.*

32 *(e)*

33 *(b) This article shall become inoperative in the event, and on*  
34 *the effective date, of a final judicial determination by any court of*  
35 *appellate jurisdiction or a final determination by the federal*  
36 *Department of Health and Human Services or the federal Centers*  
37 *for Medicare and Medicaid Services that any element of this article*  
38 *cannot be implemented.*

39 *(d)*

(c) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, all of the following shall apply:

(1) No payments shall be made to a ~~hospital~~ hospital litigant pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to a hospital litigant pursuant to this article for a subject federal fiscal year shall be withheld by the department and shall be paid to the hospital litigant only after the case or proceeding is finally resolved, including the final disposition of all appeals.

14167.20. (a) *It is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the supplemental payment to individual hospitals under this article.*

(b) *No supplemental payments shall be made pursuant to this article until the legislation described in subdivision (a) has been enacted.*

~~14167.9.~~

14167.21. This article shall remain in effect only until the earlier of the following dates and as of that date is repealed:

(a) January 1, 2013.

(b) The date the director executes a declaration, which shall be submitted to the Secretary of State, the Assembly and Senate Committees on Health, the Assembly and Senate Committees on Appropriations, the Assembly Committee on Budget, and the Senate Committee on Budget and Fiscal Review, stating that a final judicial or administrative determination described in subdivision ~~(c) of Section 14167.8~~ (b) of Section 14167.19 has been made.

SEC. 2. Article 5.22 (commencing with Section 14167.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

1 Article 5.22. Hospital Coverage Dividend Fee Act

2  
3 ~~14167.31. For purposes of this article, “subject federal fiscal~~  
4 ~~year” means a federal fiscal year ending after the effective date of~~  
5 ~~federal approval of Article 5.21 (commencing with Section~~  
6 ~~14167.1) and beginning before December 31, 2010.~~

7 *14167.31. For purposes of this article, the following definitions*  
8 *shall apply:*

9 (a) *“Phase 1” means the implementation of this article for some*  
10 *or all of the subject federal fiscal year ending September 30, 2009.*

11 (b) *“Phase 1 approval” means the federal approvals or waivers*  
12 *necessary for implementation of this article for some or all of the*  
13 *subject federal fiscal year ending September 30, 2009.*

14 (c) *“Phase 2” means the implementation of this article for some*  
15 *or all of the period beginning October 1, 2009, and ending*  
16 *December 31, 2010.*

17 (d) *“Phase 2 approval” means the federal approvals or waivers*  
18 *necessary for implementation of this article for the period*  
19 *beginning October 1, 2009, and ending December 31, 2010.*

20 (e) *“Subject federal fiscal year” means a federal fiscal year*  
21 *ending on or after the effective date of federal approval of Article*  
22 *5.21 (commencing with Section 14167.1) and beginning on or*  
23 *before December 31, 2010.*

24 14167.32. (a) There shall be imposed a coverage dividend fee  
25 that is consistent with the principle of shared benefit and shared  
26 responsibility.

27 ~~(b) The coverage dividend fee shall be assessed on hospitals,~~  
28 ~~except for designated public hospitals, as defined in subdivision~~  
29 ~~(a) of Section 14167.1, starting on the date that this article becomes~~  
30 ~~effective and shall continue through and including December 31,~~  
31 ~~2010.~~

32 (b) *The coverage dividend fee shall be assessed on hospitals*  
33 *licensed pursuant to subdivision (a) of Section 1250 of the Health*  
34 *and Safety Code, except for public hospitals, as defined in*  
35 *paragraph (25) of subdivision (a) of Section 14105.98, and*  
36 *hospitals that are designated as specialty hospitals in the hospital’s*  
37 *annual financial disclosure reports for the hospital’s latest fiscal*  
38 *year ending in 2008, commencing on the effective date of this*  
39 *article and shall continue through and including December 31,*  
40 *2010.*

1 (c) The department shall calculate the amount of the coverage  
2 dividend fee for each hospital within 10 days after the date when  
3 this article becomes effective. Within two days of calculating the  
4 coverage dividend fee, the department shall send notice of the  
5 amount of the coverage dividend fee to each hospital.

6 ~~(d) For calendar quarters prior to federal approval of the~~  
7 ~~implementation of this article and for the calendar quarter when~~  
8 ~~the department receives notice of federal approval of the~~  
9 ~~implementation of this article, the following provisions shall apply:~~

10 ~~(1) For the calendar quarters, and partial quarters thereof,~~  
11 ~~between the date that this article becomes effective and September~~  
12 ~~30, 2009, inclusive, the following provisions shall apply:~~

13 ~~(A) If this article becomes effective on or before June 30, 2009,~~  
14 ~~the following provisions shall apply:~~

15 ~~(i) On the later of 10 days after this article becomes effective~~  
16 ~~or May 15, 2009, each hospital shall certify, under penalty of~~  
17 ~~perjury, and to the best of its knowledge, on a form provided by~~  
18 ~~the department, that it has set aside in a separate account an amount~~  
19 ~~equal to the coverage dividend fee for that hospital divided by the~~  
20 ~~number of days from the date that this article becomes effective~~  
21 ~~to September 30, 2009, inclusive, multiplied by the number of~~  
22 ~~days from the date that this article becomes effective to June 30,~~  
23 ~~2009, inclusive.~~

24 ~~(ii) On or before August 15, 2009, each hospital shall certify,~~  
25 ~~under penalty of perjury, and to the best of its knowledge, on a~~  
26 ~~form provided by the department, that it has set aside in a separate~~  
27 ~~account an amount equal to the coverage dividend fee for that~~  
28 ~~hospital divided by the number of days from the date that this~~  
29 ~~article becomes effective to September 30, 2009, inclusive,~~  
30 ~~multiplied by the number of days from July 1, 2009, to September~~  
31 ~~30, 2009, inclusive.~~

32 ~~(B) If this article becomes effective on or after July 1, 2009, on~~  
33 ~~the later of 10 days after this article becomes effective or August~~  
34 ~~15, 2009, each hospital shall certify, under penalty of perjury, and~~  
35 ~~to the best of its knowledge, on a form provided by the department,~~  
36 ~~that it has set aside in a separate account an amount equal to the~~  
37 ~~coverage dividend fee for that hospital.~~

38 ~~(2) For each calendar quarter beginning on or after October 1,~~  
39 ~~2009, and ending on or before September 30, 2010, within 45 days~~  
40 ~~following the beginning of each calendar quarter, each hospital~~

1 shall certify, under penalty of perjury, and to the best of its  
2 knowledge, on a form provided by the department, that it has set  
3 aside in a separate account an amount equal to the coverage  
4 dividend fee for that hospital divided by four.

5 (3) For the calendar quarter beginning October 1, 2010, on or  
6 before November 15, 2010, each hospital shall certify, under  
7 penalty of perjury, and to the best of its knowledge, on a form  
8 provided by the department, that it has set aside in a separate  
9 account an amount equal to the coverage dividend fee for that  
10 hospital.

11 (4) All certifications required by this subdivision shall include  
12 a certification from each hospital that it has maintained any  
13 coverage dividend fee amounts previously set aside in a separate  
14 account in that separate account, and that within 30 days after  
15 federal approval of the implementation of this article, the hospital  
16 shall pay the principal amount of the coverage dividend fee set  
17 aside in a separate account to the department pursuant to paragraph  
18 (2) of subdivision (e).

19 (e) Upon federal approval of the implementation of this article,  
20 all of the following shall become operative:

21 (1) Within 10 days following the notice of approval by the  
22 federal government of the implementation of this article, the  
23 department shall send notice to providers, and publish on its  
24 Internet Web site the following information:

25 (A) The date that the state received notice of federal approval  
26 of the implementation of this article.

27 (B) The percentage of the fee that shall be collected to meet the  
28 federal upper payment limit, as defined in subdivision (b) of  
29 Section 14167.1.

30 (C) A notice to each hospital subject to the coverage dividend  
31 fee stating all of the following:

32 (i) That the hospital shall, within 30 days after the date the  
33 department received notice of federal approval of the  
34 implementation of this article, pay the principal amounts of the  
35 coverage dividend fee set aside in a separate account to the  
36 department multiplied by the percentage of the fee that will be  
37 collected to meet the federal upper payment limit as described in  
38 subparagraph (B):

39 (ii) The total amount of the fee that will be payable by the  
40 hospital on the date described in clause (i):

1     ~~(2) Within 30 days after the date the department receives notice~~  
2 ~~of federal approval, each hospital shall pay the principal amount~~  
3 ~~of the coverage dividend fee the hospital has certified pursuant to~~  
4 ~~subdivision (d) that the hospital has set aside in a separate account~~  
5 ~~to the department multiplied by the percentage of the fee that shall~~  
6 ~~be collected to meet the federal upper payment limit as described~~  
7 ~~in subparagraph (B) of paragraph (1). Any money set aside in a~~  
8 ~~separate account in excess of the amount the hospital is obligated~~  
9 ~~to pay to the department may be returned to the general accounts~~  
10 ~~of each hospital.~~

11     ~~(3) Subdivision (d) shall become inoperative beginning the first~~  
12 ~~day of the first calendar quarter following the quarter in which the~~  
13 ~~department receives notice of approval by the federal government~~  
14 ~~of the implementation of this article.~~

15     ~~(4) Within 45 days following the beginning of each calendar~~  
16 ~~quarter, commencing with the quarter in which the department~~  
17 ~~receives notice of federal approval and ending with, and including,~~  
18 ~~the calendar quarter ending December 31, 2010, each hospital shall~~  
19 ~~pay to the department the amounts that the hospital would have~~  
20 ~~certified to pay for the relevant quarter pursuant to subdivision (d)~~  
21 ~~multiplied by the percentage of the fee that will be collected to~~  
22 ~~meet the federal upper payment limit described in subparagraph~~  
23 ~~(B) of paragraph (1).~~

24     ~~(5) The coverage dividend fee, as paid pursuant to this~~  
25 ~~subdivision, shall be paid by each hospital subject to the fee and~~  
26 ~~paid to the department for deposit in the Coverage Dividend~~  
27 ~~Revenue Fund created pursuant to Section 14167.35. Deposits into~~  
28 ~~the fund may be accepted at any time and shall be credited toward~~  
29 ~~the fiscal year for which they were assessed.~~

30     ~~(f) (1) Subdivision (d) shall become inoperative if either of the~~  
31 ~~following situations occur:~~

32     ~~(A) The federal Centers for Medicare and Medicaid Services~~  
33 ~~denies approval for the implementation of Article 5.21~~  
34 ~~(commencing with Section 14167.1) or this article and neither~~  
35 ~~article can be modified by the department pursuant to subdivision~~  
36 ~~(g) of Section 14167.35 in order to meet the requirements of federal~~  
37 ~~law or to obtain federal approval.~~

38     ~~(B) The federal Centers for Medicare and Medicaid Services~~  
39 ~~does not approve the implementation of Article 5.21 (commencing~~  
40 ~~with Section 14167.1) or this article on or before January 1, 2012.~~

~~(2) If subdivision (d) becomes inoperative pursuant to this subdivision, each hospital subject to the coverage dividend fee shall be released from any certifications made pursuant to subdivision (d) and any amounts previously set aside in a separate account and any interest incurred on those amounts may be returned to the general accounts of each hospital.~~

~~(g) In no case shall the aggregate fees collected on an annual fiscal year basis pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.~~

*(d) For calendar quarters, and partial quarters thereof, in phase 1, the following provisions shall apply:*

*(1) Within 30 days after the effective date of this article, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay the coverage dividend fee for that hospital for the subject federal fiscal year by the later of 30 days after phase 1 approval or August 15, 2009.*

*(2) Upon phase 1 approval, all of the following shall become operative:*

*(A) Within 10 days following the notice of phase 1 approval, the department shall send notice to providers, and publish on its Internet Web site, the following information:*

*(i) The date that the state received notice of phase 1 approval.*

*(ii) The percentage of the fee that shall be collected to meet the federal upper payment limit, as defined in subdivision (e) of Section 14167.1.*

*(B) The notice to each hospital subject to the coverage dividend fee shall also state all of the following:*

*(i) That the hospital shall pay the coverage dividend fee for the subject federal fiscal year, multiplied by the percentage of the fee that will be collected to meet the federal upper payment limit as described in clause (ii) of subparagraph (A), by the later of 30 days after phase 1 approval or August 15, 2009.*

*(ii) The total amount of the fee that will be payable by the hospital on the date described in clause (i).*



1 (C) By the later of 30 days after phase 1 approval or August  
2 15, 2009, each hospital shall pay the amounts stated in the  
3 department's notice pursuant to subparagraph (B).

4 (e) For calendar quarters in phase 2, the following provisions  
5 shall apply:

6 (1) For calendar quarters prior to phase 2 approval, and for  
7 the calendar quarter when the department receives notice of phase  
8 2 approval, the following provisions shall apply:

9 (A) For each calendar quarter beginning on or after October  
10 1, 2009, and ending on or before September 30, 2010, within 45  
11 days following the beginning of each calendar quarter, each  
12 hospital shall certify, under penalty of perjury, and to the best of  
13 its knowledge, on a form provided by the department, that the  
14 hospital is prepared to pay an amount equal to the coverage  
15 dividend fee for that hospital for the subject federal fiscal year  
16 divided by four, in addition to any amounts that it has previously  
17 certified it was prepared to pay, within 30 days after phase 2  
18 approval.

19 (B) For the calendar quarter beginning on October 1, 2010,  
20 each hospital shall, on or before November 15, 2010, certify, under  
21 penalty of perjury, and to the best of its knowledge, on a form  
22 provided by the department, that the hospital is prepared to pay  
23 an amount equal to the coverage dividend fee for that hospital for  
24 the subject federal fiscal year, in addition to any amounts that it  
25 has previously certified it was prepared to pay, within 30 days  
26 after phase 2 approval.

27 (2) Upon phase 2 approval, all of the following shall become  
28 operative:

29 (A) Within 10 days following the notice of phase 2 approval,  
30 the department shall send notice to providers, and publish on its  
31 Internet Web site, the following information:

32 (i) The date that the state received notice of phase 2 approval.

33 (ii) The percentage of the fee that shall be collected to meet the  
34 federal upper payment limit, as defined in subdivision (e) of Section  
35 14167.1.

36 (B) The notice to each hospital subject to the coverage dividend  
37 fee shall also state all of the following:

38 (i) That the hospital shall, within 30 days after the date the  
39 department received notice of phase 2 approval, pay the amounts  
40 of the coverage dividend fee that the hospital had previously

1 *certified it was prepared to pay pursuant to paragraph (1),*  
2 *multiplied by the percentage of the fee that will be collected to*  
3 *meet the federal upper payment limit as described in clause (ii) of*  
4 *subparagraph (A).*

5 *(ii) The total amount of the fee that will be payable by the*  
6 *hospital on the date described in clause (i).*

7 *(C) Within 30 days after the date the department receives notice*  
8 *of phase 2 approval, each hospital shall pay the amounts stated*  
9 *in the department's notice pursuant to this paragraph.*

10 *(D) Paragraph (1) shall become inoperative beginning the first*  
11 *day of the first calendar quarter following the quarter in which*  
12 *the department receives notice of phase 2 approval.*

13 *(E) Within 45 days following the beginning of each calendar*  
14 *quarter, commencing with the quarter following the last quarter*  
15 *governed by paragraph (1) and ending with, and including, the*  
16 *calendar quarter ending December 31, 2010, each hospital shall*  
17 *pay to the department the amounts that the hospital would have*  
18 *certified to pay for the relevant quarter pursuant to paragraph (1)*  
19 *multiplied by the percentage of the fee that will be collected to*  
20 *meet the federal upper payment limit described in clause (ii) of*  
21 *subparagraph (A).*

22 *(f) The coverage dividend fee, as paid pursuant to this*  
23 *subdivision, shall be paid by each hospital subject to the fee and*  
24 *paid to the department for deposit in the Coverage Dividend*  
25 *Revenue Fund created pursuant to Section 14167.35. Deposits*  
26 *into the fund may be accepted at any time and shall be credited*  
27 *toward the fiscal year for which they were assessed.*

28 *(g) (1) Subdivision (d) shall become inoperative if the federal*  
29 *Centers for Medicare and Medicaid Services denies approval for,*  
30 *or does not approve before January 1, 2012, the implementation*  
31 *of Article 5.21 (commencing with Section 14167.1) or this article*  
32 *for phase 1, and neither article can be modified by the department*  
33 *pursuant to subdivision (g) of Section 14167.35 in order to meet*  
34 *the requirements of federal law or to obtain federal approval.*

35 *(2) Subdivision (e) shall become inoperative if the federal*  
36 *Centers for Medicare and Medicaid Services denies approval for,*  
37 *or does not approve before January 1, 2012, the implementation*  
38 *of Article 5.21 (commencing with Section 14167.1) or this article*  
39 *for phase 2, and neither article can be modified by the department*

1 *pursuant to subdivision (g) of Section 14167.35 in order to meet*  
2 *the requirements of federal law or to obtain federal approval.*

3 *(3) If subdivision (d) or (e) becomes inoperative pursuant to*  
4 *this subdivision, each hospital subject to the coverage dividend*  
5 *fee shall be released from any certifications made pursuant to*  
6 *subdivision (d) or (e).*

7 *(h) In no case shall the aggregate fees collected in a subject*  
8 *federal fiscal year pursuant to this section exceed the maximum*  
9 *percentage of the annual aggregate net patient revenue for*  
10 *hospitals subject to the fee that is prescribed pursuant to federal*  
11 *law and regulations as necessary to preclude a finding that an*  
12 *indirect guarantee has been created.*

13 ~~(h)~~

14 *(i) Interest shall be assessed on coverage dividend fees not paid*  
15 *on the date due at the same rate at which the department assesses*  
16 *interest on Medi-Cal program overpayments to hospitals that are*  
17 *not repaid when due. Interest shall begin to accrue the day after*  
18 *the date the payment was due and shall be deposited in the*  
19 *Coverage Dividend Revenue Fund.*

20 ~~(i)~~

21 *(j) When a hospital fails to pay all or part of the coverage*  
22 *dividend fee within 60 days of the date that payment is due, the*  
23 *department may deduct the unpaid assessment and interest owed*  
24 *from any Medi-Cal payments to the hospital until the full amount*  
25 *is recovered. Any deduction shall be made only after written notice*  
26 *to the hospital and may be taken over a period of time. All amounts*  
27 *deducted by the department pursuant to this subdivision shall be*  
28 *deposited in the Coverage Dividend Revenue Fund.*

29 ~~(j)~~

30 *(k) In accordance with the provisions of the Medicaid state plan,*  
31 *the payment of the coverage dividend fee shall be considered as*  
32 *an allowable cost for Medi-Cal cost reporting and reimbursement*  
33 *purposes.*

34 ~~(k)~~

35 *(l) The department shall work in consultation with the hospital*  
36 *community to implement the coverage dividend fee.*

37 ~~(l)~~

38 *(m) The department shall offer to enter into a contract with each*  
39 *hospital subject to the coverage dividend fee, or to amend existing*  
40 *contracts with the hospital, that obligates the department to use*

1 the proceeds of the coverage dividend fee solely for the purposes  
2 set forth in this article and to comply with all of its obligations set  
3 forth in Article 5.21 (commencing with Section 14167.1) and this  
4 article, including, but not limited to, its obligation to continue prior  
5 reimbursement levels. Each contract shall also provide that the  
6 hospital's obligation to pay the coverage dividend fee shall be  
7 contingent on the department performing its obligations under the  
8 contract. Each contract shall be binding on the department and  
9 enforceable by the hospitals regardless of whether the hospitals  
10 have given adequate consideration in return for the department's  
11 obligations.

12 *(n) Any amounts of the coverage dividend fee collected in excess*  
13 *of the funds required to implement subdivision (c) of Section*  
14 *14167.35 shall be refunded to the hospitals subject to the coverage*  
15 *dividend fee, in a manner consistent with federal law.*

16 14167.35. (a) The Coverage Dividend Revenue Fund is hereby  
17 created in the State Treasury. Notwithstanding Section 16305.7  
18 of the Government Code, any interest earned on deposits in the  
19 fund shall be retained in the fund for purposes specified in  
20 subdivision (c).

21 (b) All fees and interest required to be paid to the state pursuant  
22 to this article shall be paid in the form of remittances payable to  
23 the department. The department shall directly transmit the  
24 payments to the Treasurer to be deposited in the Coverage Dividend  
25 Revenue Fund.

26 (c) All funds in the Coverage Dividend Revenue Fund, together  
27 with any interest, and penalties, shall be used only for the following  
28 purposes in the following order of priority, subject to the  
29 requirements of subdivision (d):

30 (1) To make increased payments to hospitals pursuant to Article  
31 5.21 (commencing with Section 14167.1).

32 (2) To pay for the expansion of health care coverage for children  
33 beyond existing levels. *The maximum amount of the coverage*  
34 *dividend fee that may be used for this purpose shall be eighty*  
35 *million dollars (\$80,000,000) for each quarter during the 2008–09*  
36 *federal fiscal year that begins after the actual date on which all*  
37 *federal approvals are obtained that are necessary to implement*  
38 *Article 5.21 (commencing with Section 14167.1) and this article*  
39 *for phase 1, and each quarter that begins after the actual date on*  
40 *which all federal approvals are obtained that are necessary to*

1 *implement Article 5.21 (commencing with Section 14167.1) and*  
2 *this article for phase 2 and ends on or before December 31, 2010.*

3 (3) *To be used to make the increased payments to managed*  
4 *health care plans pursuant to Article 5.21 (commencing with*  
5 *Section 14167.1). The amount used for making increased payments*  
6 *to managed health care plans shall be limited to the maximum*  
7 *amount approved by the federal Centers for Medicare and*  
8 *Medicaid Services for purposes of federal financial participation.*

9 (d) No portion of the Coverage Dividend Revenue Fund shall  
10 be used in support of the administration of the department except  
11 that these fees may be used in combination with federal funds to  
12 fund the actual cost of collecting the fee.

13 (e) Notwithstanding Section 13340 of the Government Code,  
14 the Coverage Dividend Revenue Fund shall be continuously  
15 appropriated to the department for the purposes described in  
16 subdivision (c) without regard to fiscal year.

17 (f) In seeking federal approval pursuant to Section 14167.37,  
18 the department shall seek specific approval from the federal Centers  
19 for Medicare and Medicaid Services to exempt providers identified  
20 in this article as exempt from the fees specified, including the  
21 submission, as may be necessary, of a request for waiver of the  
22 broad-based requirement, waiver of the uniform tax requirement,  
23 or both, pursuant to Section 433.68(e)(1) and (e)(2) of Title 42 of  
24 the Code of Federal Regulations. *The department shall separately*  
25 *seek approval for phase 1 and for phase 2.*

26 (g) Any methodology specified in Article 5.21 (commencing  
27 with Section 14167.1) and this article may be modified by the  
28 department, in consultation with the hospital community, to the  
29 extent necessary to meet the requirements of federal law or  
30 regulations or to obtain federal approval, provided the  
31 modifications do not violate the intent of Article 5.21 (commencing  
32 with Section 14167.1) or this article and are not inconsistent with  
33 the conditions of implementation set forth in subdivisions (a) and  
34 (c) of Section 14167.36.

35 (h) The department, in consultation with the hospital community,  
36 shall make retrospective adjustments, as necessary, to the amounts  
37 calculated pursuant to Section 14167.32 in order to ensure  
38 compliance with the federal limits set forth in Section 433.68 of  
39 Title 42 of the Code of Federal Regulations or elsewhere in federal  
40 law.

1 14167.36. (a) This article shall only be implemented so long  
2 as the following conditions are met:

3 (1) The coverage dividend fee is established in a manner  
4 consistent with this article.

5 (2) The coverage dividend fee is deposited, including any  
6 interest on the fee after collection by the department, in a  
7 segregated fund apart from the General Fund.

8 (3) The proceeds of the coverage dividend fee, including any  
9 interest, penalties, and related federal reimbursement, are only  
10 used for the purposes set forth in this article.

11 (b) No hospital shall be required to pay the coverage dividend  
12 fee to the department unless and until the state receives and  
13 maintains federal approval of the coverage dividend fee and Article  
14 5.21 (commencing with Section 14167.1) from the federal Centers  
15 for Medicare and Medicaid Services *for the period for which the*  
16 *coverage dividend fee is assessed.*

17 (c) Hospitals shall be required to pay the coverage dividend fee  
18 to the department as set forth in this article only as long as all of  
19 the following conditions are met:

20 (1) The federal Centers for Medicare and Medicaid Services  
21 allows the use of the coverage dividend fee as set forth in this  
22 article *for the period for which the coverage dividend fee is*  
23 *assessed.*

24 (2) The Medi-Cal Hospital Provider Rate Stabilization Act  
25 (Article 5.21 (commencing with Section 14167.1)) is enacted and  
26 remains in effect and hospitals are reimbursed the increased rates  
27 beginning on the implementation date, as defined in subdivision  
28 (e) of Section 14167.1.

29 (3) The full amount of the coverage dividend fee assessed and  
30 collected pursuant to this article remains available only for the  
31 purposes specified in this article.

32 (d) This article shall become inoperative in the event, and on  
33 the effective date, of a final judicial determination made by any  
34 state or federal court that is not appealed, or by a court of appellate  
35 jurisdiction that is not further appealed, in any action by any party,  
36 or a final determination by the administrator of the federal Centers  
37 for Medicare and Medicaid Services, that the coverage dividend  
38 fee assessed and collected pursuant to this article cannot be  
39 implemented.

1 ~~14167.37. (a) The director shall seek federal approval for the~~  
2 ~~implementation of each element of this article. If after seeking~~  
3 ~~federal approval, federal approval is denied, this article shall~~  
4 ~~become inoperative.~~

5 *14167.37. (a) The director shall seek federal approval for the*  
6 *implementation of each element of this article. If, after seeking*  
7 *phase 1 approval, federal approval is denied, this article shall*  
8 *become inoperative during the period between the date that this*  
9 *article becomes effective and September 30, 2009. If, after seeking*  
10 *phase 2 approval, federal approval is denied, this article shall*  
11 *become inoperative during the period between October 1, 2009,*  
12 *and December 31, 2010.*

13 (b) Each and every report or informational submission required  
14 from providers pursuant to this article shall contain a legal  
15 verification to be signed by the provider verifying under penalty  
16 of perjury that the information provided is true and correct, and  
17 that any information in supporting documents submitted by the  
18 provider is true and correct.

19 *14167.38. (a) It is the intent of the Legislature to enact*  
20 *additional legislation that will specify more precisely the*  
21 *calculation of the amount of the coverage dividend fee due from*  
22 *individual hospitals under this article.*

23 *(b) No coverage dividend fee shall be made due or payable*  
24 *pursuant to this article until the legislation described in subdivision*  
25 *(a) has been enacted.*

26 ~~14167.38.~~

27 *14167.39. This article shall remain in effect only until the*  
28 *earlier of the following dates and as of that date is repealed:*

29 (a) January 1, 2013.

30 (b) The date the director executes a declaration, which shall be  
31 submitted to the Secretary of State, the Assembly and Senate  
32 Committees on Health, the Assembly and Senate Committees on  
33 Appropriations, the Assembly Committee on Budget, and the  
34 Senate Committee on Budget and Fiscal Review, stating any one  
35 of the following:

36 (1) One or more of the conditions listed in subdivision (a) of  
37 Section 14167.36 have not been met.

38 (2) A final judicial or administrative determination described  
39 in subdivision (d) of Section 14167.36 has been made.

1 (3) Federal approval for implementation of this article has been  
2 denied.

3 SEC. 3. No reimbursement is required by this act pursuant to  
4 Section 6 of Article XIII B of the California Constitution because  
5 the only costs that may be incurred by a local agency or school  
6 district will be incurred because this act creates a new crime or  
7 infraction, eliminates a crime or infraction, or changes the penalty  
8 for a crime or infraction, within the meaning of Section 17556 of  
9 the Government Code, or changes the definition of a crime within  
10 the meaning of Section 6 of Article XIII B of the California  
11 Constitution.

12 SEC. 4. This act is an urgency statute necessary for the  
13 immediate preservation of the public peace, health, or safety within  
14 the meaning of Article IV of the Constitution and shall go into  
15 immediate effect. The facts constituting the necessity are:

16 In order to make the necessary statutory changes to increase  
17 Medi-Cal payments to hospitals and improve access, at the earliest  
18 possible time, so as to allow this act to be operative as soon as  
19 approval from the federal Centers for Medicare and Medicaid  
20 Services is obtained by the State Department of Health Care  
21 Services, it is necessary that this act take effect immediately.